STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012582	A. BUILDING: _____ B. WING _____	C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE II, LLC	4411 PARK PLACE DR FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00156166. Complaint IN00156166 - Substantiated, no deficiencies related to the allegations were cited. Survey Dates: October 7, 8 & 9, 2014 Facility number: 012582 Provider number: N/A AIM number: N/A Survey team: Angela Strass, RN Census bed type: Residential: 117 Total: 117 Census payor type: Medicaid: 19 Other: 98 Total: 117 Sample: 5 Park Place II, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00156166. Quality Review 10/10/14 by Lisa McColly	R 000		